CIS High Deductible Health Plan 4 w/ HSA Alternative Care

Benefits Summary
Effective January 1, 2026 – December 31, 2026

cis benefits
www.cisbenefits.org

This medical and pharmacy plan is insured by CIS, but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical and pharmacy services and supplies.

HDHP 4 w/ HSA	
Deductible Per Calendar Year	$1,700 Individual $3,400 Family
Out-of-Pocket Maximum Per Calendar Year *includes deductible, medical copays and prescription copays*	$3,400 Individual $6,800 Family
Important Note: The Individual Deductible and Out-of-Pocket Maximum apply only if you are enrolled in Employee Only coverage. If you have other family members on the plan, the Family Deductible must be met before the plan begins to pay. Likewise, the Family Out-of-Pocket Maximum must be satisfied before the plan will pay 100% of the allowed amount for any individual on the plan.	

Medical Services	**Member Pays** **Category 1 - Preferred** **Category 2 - Participating**	**Member Pays** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% (*deductible waived*)	40% (*after deductible*)
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath, urgent/immediate care center or virtual care)*	0% for first 3 visits for Primary Care and Behavioral Health combined 20% for additional office visits	40%
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible – Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20%	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	40%
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible – Member Pays**	
Acupuncture – *12 visits per year*	20%	40%
Ambulance	20%	
Bariatric surgery to treat obesity – *1 surgery per claimant lifetime* *Does not accumulate towards the out-of-pocket maximum*	$1,000 copay then 20% Blue Distinction Centers only	
Chiropractic Spinal Manipulations – *20 visits per year*	20%	40%
Durable Medical Equipment	20%	40%
Hearing Aids – *1 hearing aid per ear every calendar year up to age 26*	20%	40%
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days per lifetime*	20%	40%
Rehabilitation Services - *Inpatient: Unlimited / Outpatient: 77 visits per year (visit limit shared with Neurodevelopmental therapy)*	20%	40%
Weight management and nutritional counseling - *4 visits per year*	0%	40%

Other services included in your CIS medical plan	Contact Information
Hinge Health - Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, there's no additional cost to you.	To learn more, please call (855) 902-2777 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Hinge Health.
Lantern– A comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons. By using the Lantern benefit, you may also save money through reduced financial responsibility.	To learn more, please call (833) 603-0511, go to mysurgery.lanterncare.com.
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more, please call (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Telehealth. Scroll down to Resources and click on MDLIVE.
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on BeyondWell.
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Care Management.
Pregnancy Program – Provides childbirth to newborn resources.	To learn more, please call (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Pregnancy Program.
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call (800) 810-BLUE (2583).

Prescription Medication Benefit	At the Pharmacy (30-day supply) Member Pays	At the Pharmacy (90-day supply) or Mail Order thru Amazon (90-day supply) Member Pays
Individual deductible per calendar year	Shared with Medical Services	
Out-of-pocket maximum each calendar year	Shared with Medical Services	
Tier 1 (Preferred Generic)	20% Retail/Mail Order Prescription	
Tier 2 (Non-Preferred Generic)		
Tier 3 (Preferred Brand)		
Tier 4 (Non-Preferred Brand)		
Tier 5 (Generic and Preferred Brand Specialty)	20%	N/A
Tier 6 (Non-Preferred Specialty)	20%	N/A
Compound Medications	20%	N/A
Limitations and Exceptions	Prescription drugs not on the Drug List are not covered, unless an exception is approved. No charge, deductible does not apply for certain preventive medications and immunizations, including those specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. Deductible does not apply for insulin. Cost shares for insulin will not exceed $35 / 30-day supply or $105 / 90-day supply. Covered drugs limited to: 90-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / specialty drug prescription 30-day supply / compound medications Specialty medications must be filled through Accredo Specialty Pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written." More information about prescription drug coverage is available at https://regence.com/go/2026/OR/6tierLG	

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. For a detailed description of your plan benefits, visit www.regence.com on or after January 1, 2026. You must set up an account to review your specific plan booklet.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1-888-370-6159. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-888-370-6159 to request a copy. **Note:** Your medical plan is provided and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,700 individual (single coverage) / $3,400 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,400 individual (single coverage) / $6,800 family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed $6,800.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1-888-370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for upfront office visits; 20% coinsurance for additional office visits; 20% coinsurance for other services	20% coinsurance	40% coinsurance	First 3 upfront office visits / year. Limit is for primary care and behavioral health visits combined.
	Specialist visit	20% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	40% coinsurance	Coinsurance and deductible waived for childhood immunizations from non-participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2026/OR/6tierLGStd	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for insulin. No charge, deductible does not apply for drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / home delivery prescription 30-day supply / specialty drug prescription 30-day supply / compound medications Specialty drugs are not available through home
	Tier 2 (Typically, generic drugs with moderate overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	
	Tier 3 (Typically, brand drugs with	Not applicable, refer to participating provider and non-	20% coinsurance / retail prescription; 20% coinsurance /	20% coinsurance / retail prescription; 20% coinsurance /	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	moderate overall value)	participating provider columns.	home delivery prescription	home delivery prescription	delivery. Coverage includes compound medications at 20% coinsurance. Cost shares for insulin will not exceed $35 / 30-day supply or $105 / 90-day supply. No charge, deductible does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written." The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 4 (Typically, brand drugs with lower overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	
	Tier 5 (Typically, specialty drugs with moderate overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / specialty drug	20% coinsurance / specialty drug	
	Tier 6 (Typically, specialty drugs with lower overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / specialty drug	20% coinsurance / specialty drug	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for upfront office or psychotherapy visits; 20% coinsurance for additional office or psychotherapy visits; 20% coinsurance for other services	20% coinsurance	40% coinsurance	First 3 upfront visits / year. Limit is for primary care and behavioral health visits combined.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	77 visits / year for all habilitation and outpatient rehabilitation services Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services.
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture, 12 visits / year
- Bariatric surgery, 1 surgery / lifetime
- Chiropractic care, spinal manipulation 20 visits / year
- Hearing aids (individuals up to age 26), 1 per ear / 36 months
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1-888-370-6159. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-888-370-6159 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1-503-947-7984 or the toll-free message line at 1-888-877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-370-6159.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of preferred provider pre-natal care and a hospital delivery)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

Managing Joe's Type 2 Diabetes
(a year of routine preferred provider care of a well-controlled condition)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,400**

Mia's Simple Fracture
(preferred provider emergency room visit and follow up care)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

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ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

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โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

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Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)